

**NOTICE OF POSSIBLE
SECOND INJURY FUND
CLAIM**

W.C.C No. _____

Carrier Code _____

Employer Code _____

Carrier File No. _____

S.I.F. No. _____

Employee: Address:	Social Security No.: Date of Accident:
Employer: Location:	Carrier: Address:
Employee's Attorney: Address:	Carrier's Attorney: Address:
<u>SUBSEQUENT INJURY:</u> Nature of Second Injury: _____ _____ Current Status: _____ _____ Treating Physicians: _____ _____ Average Weekly Wage: _____ Compensation Rate: _____ Date of First Temporary Total: _____ Date Returned to Work: _____ Weeks of All Benefits Paid: _____ Medical Costs to Date: _____	
<u>NATURE OF PRIOR IMPAIRMENT:</u> Refer to Secion 42-9-400, Paragraph (d) <input type="checkbox"/> List Impairment (1-33): _____ <input type="checkbox"/> Other (34 a or b): _____	
<u>KNOWLEDGE REQUIREMENT:</u> <input type="checkbox"/> Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.) <input type="checkbox"/> Employee withheld existence of pre-existing condition from employer. (Please attach application, pre-employment physical, etc.) <input type="checkbox"/> Employee was unaware of existence of pre-existing condition. (Please attach affidavit)	
<u>THESE FORMS MUST BE PROVIDED BEFORE CLAIMS CAN BE PROCESSED:</u> <div style="text-align: right; margin-top: 10px;">(1) All narrative medical reports (2) Form 12-A (3) Form 15 (4) Current Form 18 (5) Any W.C.C. Order</div>	
Signature: Mailing Address:	Date of Claim:

In support of such notice and without precluding the right to establish further facts as may be developed, the preceding allegations are set forth subject to proof at a Hearing.

PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE WORKERS' COMPENSATION COMMISSION.